IMPORTANT NOTICE

Any person injured in an accident or incident involving a City of Detroit Bus (NOT A SMART BUS OR A DETROIT PUBLIC SCHOOL BUS) may, under the laws of the State of Michigan, claim No Fault benefits from:

FIRST: Their own automobile insurance carrier.

SECOND: The Automobile insurance carrier of any relative living in their household.

THIRD: The City of Detroit. (Only involving a Detroit Department of Transportation Bus)

If an injured party or any relative living in the same household owns an automobile, DO NOT complete the attached form. Please IMMEDIATELY contact the insurance carrier that issued an insurance policy on the automobile.

Thank you.

Ciy of Detroit Law Department
Litigation Division: Claims Section
1650 First National Building
Detroit, MI 48226
(313) 224-4550
www.detroitmi.gov
/departments/law/litigation/claims section

AUTHORIZATION FOR
WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

_____

Name of Employee (Printed)

_____ _____

Signature Date

_____

Social Security No.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date	Date of Accident	File Number
Applicant's Name	Home Phone Number	Business Phone Number
Address	Date of Birth	Social Security No.
Date & Time of Accident (am/pm)	Place of Incident (Exact Location)	
Brief Description of Accident:		
As a result of the incident were you injured? ☐Yes ☐No If yes, please complete the rest of this form.		
Describe your injury		
Were you treated in a Hospital? ☐Yes ☐ No If yes, please list Hospitals Name and Address.		
Were you treated by a Doctor? ☐ Yes ☐ No If yes, please list Doctor's Name and Address.		

I, THE UNDERSIGNED, HEREBY AUTHORIZE ANY PHYSICIAN OR NURSE WHO ATTENDED THE ABOVE NAMED, OR ANY HOSPITAL AT WHICH ABOVE NAMED HAS BEEN CONFINED, TO FURNISH THE CITY OF DETROIT LAW DEPARTMENT, WITH ANY AND ALL INFORMATION WHICH MAY BE REQUESTED REGARDING PAST PHYSICAL CONDITION AND TREATMENT RENDERED AND TO ALLOW THEM OR ANY PHYSICIAN APPOINTED BY THEM TO EXAMINE AND COPY ANY AND ALL RECORDS WHICH YOU MAY HAVE REGARDING CONDITION OR TREATMENT, INCLUDING ALCOHOL AND DRUG PART 2, IF ANY; PSYCHOLOGICAL SERVICES AND SOCIAL SERVICES RECORDS INCLUDING COMMUNICATIONS MADE TO A SOCIAL WORKER OR PSYCHOLOGIST OR PSYCHIATRIST, IF ANY; RECORDS OF COMMUNICABLE DISEASES AND SERIOUS COMMUNICABLE DISEASES AND INFECTIONS, VENEREAL DISEASE (VD), TUBERCULOSIS (TB), HEPATITIS B, HUMAN IMMUNODEFICIENCY VIRUS (HIV), ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND AIDS RELATED COMPLEX (ARC), IF ANY. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE ISSUER OF THE MEDICAL RELEASE. YOUR PROTECTED HEALTH INFORMATION WILL BE DISCLOSED TO ANY AGENCY INVOLVED IN THE INVESTIGATION, EVALUATION AND RESOLUTION OF YOUR MATTER AS IT RELATES TO THE CITY OF DETROIT.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER SUBJECT TO PRIVACY PROTECTION PROVIDED BY LAW.

_____ _____

NAME (Signature) DATE

_____ _____

SOCIAL SECURITY NUMBER DATE OF BIRTH

Subscribed and sworn to before me this

____ day of _____, 2010.

_____

Notary Public, Wayne County, Michigan My Commission Expires: _____

CITY OF DETROIT
LAW DEPARTMENT

FIRST NATIONAL BUILDING
660 WOODWARD AVENUE, SUITE 1650
DETROIT, MICHIGAN 48226-3535
PHONE 313•224•4550 TTY:311
FAX 313•224•5505
WWW.DETROITMI.GOV

RE: Completion of the Medicare Indemnification Affidavit

Dear Claimant:

Enclosed please find the following documents that you are required to complete, sign and have notarized:

1. Medicare Indemnification Affidavit of the City of Detroit by the Claimant/Plaintiff.

Please be advised that the above forms are required in order to complete a thorough investigation of your claim and in accordance with the Medicare, Medicaid and SCHIP Extension Act of 2007 and the Medicare Secondary Payer Laws. The City of Detroit is required by the aforementioned federal laws to provide information to the United States Government, Department of Health and Human Services, Center for Medicare and Medicaid Services or their Medicare contractor.

Please be advised that your Claim cannot be processed until you have fully completed, signed and had the above forms notarized and returned to our office.

City of Detroit Law Department
Claims Section

MEDICARE REPORTING AND INDEMNIFICATION AFFIDAVIT

_____, being first duly sworn, deposes and says that I have filed a claim and/or lawsuit against the City of Detroit:

1. I certify under penalty of law that this Affidavit and all attachments were prepared with my knowledge and were reviewed by me. The information submitted is, to the best of my knowledge and belief, true, accurate and complete. I am aware that there are significant penalties for submitting false information, including the possibility of a fine and/or imprisonment for known violations. **I hereby state under oath and subject to any penalties for perjury that the information contained in this Affidavit is true, correct and accurate.**

2. I hereby understand that the City of Detroit will be relying upon this information in order to provide all of the required information to the United States Government, Department of Health and Human Services, Center for Medicare and Medicaid Services or their Medicare contractor in accordance with the Medicare, Medicaid and SCHIP Extension Act of 2007 and to be in compliance with the Medicare Secondary Payer Laws.

Circle One

3. I am currently receiving Medicare Benefits..... yes or no

4. I will be Sixty Five years old within three years..... yes or no

4a. I have applied for Social Security Disability Benefits..... yes or no

5. I have received a Social Security Disability Award Letter and attached a copy hereto.....yes or no

6. Attached is a copy of my Social Security Disability Application.....yes or no

7. Attached is a copy of my Social Security denial letter and my appeal of said denial..... yes or no

8. I have End Stage Renal Disease.....yes or no

9. That my full name and all aliases are:

_____

_____

10. That my City of Detroit File/Matter Number is:

_____

11. That my address is:

_____

12. That my Attorney's Name, Address and Contact Numbers are:

_____

_____

13. That my Date of Birth is:

_____

14. That my Social Security Number is:

_____

15. That my Medicare HIC Number, if applicable is:

_____

16. That I am attaching copies of the following information:

a. Copy of the Judgment ..... yes or no

b. Medical Records ..... yes or no

c. Specific Description of my injuries _____

_____

17. Has anyone ever prepared for you:

a. A Life Care Plan..... yes or no

b. Medicare Set Aside Cost Projections .....yes or no

c. Life expectancy projection .....yes or no

If yes to any questions above in #17, submit a copy to the City of Detroit.

18. What specific body parts were impacted by the Injury/illness:

_____

_____

19. That my Gender is: _____ Male _____ Female

20. That the accident which gave rise to this Claim/Lawsuit occurred on:

_____ (Date)

21. On _____ (Date), a Settlement or Judgement of my Claim/Lawsuit was agreed to/rendered for the total amount of

_____ Dollars ($_____).

22. On the date of the accident/event, did any household family member own an automobile with valid No Fault Insurance coverage.....yes or no

I, _____, HAVE READ THE ABOVE MEDICARE REPORTING AND INDEMNIFICATION AFFIDAVIT AND STATE THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT AND THAT IN THE EVENT THAT THE CITY OF DETROIT IS HELD LIABLE DUE TO ANY MISINFORMATION OR OMISSION OF INFORMATION BY AFFIANT IN THIS AFFIDAVIT, AFFIANT SHALL INDEMNIFY, HOLD HARMLESS AND REIMBURSE THE CITY OF DETROIT FOR ALL PAYMENTS, DAMAGES, MONIES, COSTS, ATTORNEY'S FEES, EXPENSES, MEDICARE LIENS, MEDICARE DEMANDS FOR REIMBURSEMENT, MEDICARE OFFSETS , MEDICARE FINES, MEDICARE PENALTIES AND ANY MEDICARE PAYMENTS INCURRED BY THE CITY OF DETROIT RESULTING FROM SAID OMISSION OR MISINFORMATION. FURTHER, I SHALL FULLY COOPERATE WITH THE CITY OF DETROIT IN ANY DISPUTE OR MATTERS RELATED TO THIS INCIDENT INVOLVING MEDICARE AND SHALL EXECUTE ALL DOCUMENTS REQUIRED OR REQUESTED BY THE CITY OF DETROIT, MEDICARE OR ITS AGENTS THAT MAY BE REQUIRED OR NECESSARY TO RESOLVE ANY SAID DISPUTE OR MATTER.

FURTHER AFFIANT SAITH NOT.

_____

SIGNATURE OF THE CLAIMANT/PLAINTIFF

STATE OF MICHIGAN)
)SS
COUNTY OF _____)

This Medicare Reporting and Indemnification Affidavit was acknowledged, subscribed and sworn to before me this _____ day of _____, 2009, by _____ _____, who hereby declares under penalty of perjury under the laws of the State of Michigan that he or she is authorized in fact and law to execute this Medicare Reporting and Indemnification Affidavit.

_____
Notary Public, _____ County,MI
My Commission Expires: _____

Notary, Please ensure you use your notarial stamp or seal.

682148

CITY OF DETROIT
DEPARTMENT OF TRANSPORTATION
1301 E. Warren Ave., Detroit, Michigan 48207
LEGAL DIVISION OFFICE (313) 224-1350

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW – APPLICATION FOR BENEFITS

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW. PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

TO: _____

FOLD HERE

1. APPLICANTS NAME | PHONE NO. HOME | BUSINESS
2. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL SECURITY NO.
3. DATE AND TIME OF ACCIDENT / / A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
4. BRIEF DESCRIPTION OF ACCIDENT
5. DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD.
   AUTOMOBILE | OWNER | INSURER | POLICY NUMBER
6. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐. IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.
7. SIGNATURE: _____ DATE: _____
8. DESCRIBE YOUR INJURY
9. WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS | PHONE NUMBER
10. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS
11. AMOUNT OF MEDICAL BILLS TO DATE $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
12. DATE DISABILITY FROM WORK BEGAN | DATE YOU RETURNED TO WORK | WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER WORKMANS COMPENSATION, SOCIAL SECURITY, OR ANY OTHER WAGE OR SALARY CONTINUATION PLAN? YES ☐ NO ☐
14. LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYERS AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

15. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.
16. SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN _____ DATE: _____

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER MEDICAL INSTITUTION TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

17 _____
SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN — DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

18 _____
SIGNATURE — DATE

19 SOCIAL SECURITY NO. _____